STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155674	A. BUILDING _____ B. WING _____	R 07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CHARLES HEALTH CAMPUS	3150 ST CHARLES ST JASPER, IN 47546

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for a PSR (Post Survey Revisit) to the Recertification and State Licensure Survey completed on 5/27/11.

This visit was in conjunction with a PSR to Complaint IN00088859 and IN 00089054 investigated on 4/29/11.

Survey dates: July 19 and 20, 2011

Facility number: 002628
Provider number: 155674
AIM number: 200299110

Survey team:
Terri Walters RN TCP
Carole McDaniel RN
Martha Saull RN
Elizabeth Harper RN

Census bed type:
SNF: 12
SNF/NF: 40
Residential: 27
Total: 79

Census payor type:
Medicare: 16
Medicaid: 20
Other: 43
Total: 79

Sample: 9
Supplemental sample: 7
Residential sample: 3

St Charles Health Campus was found to be in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Rectification and State Licensure Survey. Quality review completed 7/21/11 Cathy Emswiller RN	{F 000}		